

*DRAFT*

# **Employer-Based HIV/AIDS Peer Educator Facilitator Training Manual**

**Developed through the:  
Zambia Partnership on HIV/AIDS in the Workplace**

Chainama College, Department of Counselling  
Kara Counselling  
Planned Parenthood Association of Zambia (PPAZ)  
Society for Family Health  
Zambia Business Coalition on AIDS (ZBCA)  
Zambia HIV/AIDS Business Sector (ZHABS)  
Zambia Integrated Health Programme (ZIHP)

Compiled & Edited by Ms. Lute Kazembe (ZIHP) and Ms. Lynn Van Lith (PPAZ)

## TABLE of CONTENTS

	<b>Page</b>
<b>Chapter 1:</b> What does it mean to be a Peer Educator?	3
<b>Chapter 2:</b> Workplace Issues	
<b>Chapter 3:</b> Values: Their Sources & Influences	
<b>Chapter 4:</b> Behaviour Change Communication	
<b>Chapter 5:</b> Reproductive Health & Rights	
<b>Chapter 6:</b> Family Planning	
<b>Chapter 7:</b> Sexually Transmitted Diseases (STDs)	
<b>Chapter 8:</b> HIV/AIDS	
<b>Chapter 9:</b> Basic Counselling	
<b>Chapter 10:</b> Positive Living	
<b>Chapter 11:</b> Getting Started	
<b>Chapter 12:</b> Monitoring & Evaluation	
<b>Annex I:</b> HIV Testing Sites in Zambia	
<b>Annex II:</b> Reporting Formats	

### [ADD CHAPTER: How to Use this Guide:](#)

- Read the Facilitators notes and ensure that all materials necessary are prepared.
- Give a short introduction of the topic to the participants and explain why it is important to discuss considering its link to HIV/AIDS.
- Write the objectives on a piece of paper and examine each objective with the participants.
- Display the paper on the wall where everyone will be able to refer to as the lesson proceeds.

## WORKPLACE PEER EDUCATOR TRAINING on HIV/AIDS

### TIMETABLE

#### Day 1:

08:00-8:30	Registration of participants/Introduction
08:30-9:30	Ground Rules Objectives of Workshop
09:30-10:00	Who is a Peer Educator?
<b>10:00-10:30</b>	<b>TEA BREAK</b>
10:30-11:30	Workplace Issues <ul style="list-style-type: none"><li>▪ Workplace Policy</li><li>▪ Discrimination &amp; Stigma</li></ul>
11:30-13:00	Values
<b>13:00-14:00</b>	<b>LUNCH</b>
14:00-15:00	Reproductive Health & Rights
<b>15:00-15:30</b>	<b>TEA BREAK</b>
15:30-17:00	Family Planning Condom Demonstrations (Male & Female)

#### Day 2:

08:00-8:15	Housekeeping
08:15-8:30	Review of Previous Days Work
08:30-10:00	Sexually Transmitted Diseases (STDs)
<b>10:00-10:30</b>	<b>TEA BREAK</b>
10:30-12:00	Sexually Transmitted Diseases (STDs)
12:00-13:00	HIV/AIDS—Impact & Definitions
<b>13:00-14:00</b>	<b>LUNCH</b>
14:00-15:00	HIV/AIDS—Transmission & Prevention
<b>15:00-15:30</b>	<b>TEA BREAK</b>
15:30-17:00	HIV/AIDS—Prevention Q&A

**Day 3:**

08:00-8:15	Housekeeping
08:15-8:30	Review of Previous Days Work
08:30-10:00	Personal Risk Assessment
<b>10:00-10:30</b>	<b>TEA BREAK</b>
10:30-12:00	HIV/AIDS—Voluntary Counseling & Testing (VCT)
12:00-13:00	Positive Living
<b>13:00-14:00</b>	<b>LUNCH</b>
14:00-15:00	Basic Counseling & Listening Skills
<b>15:00-15:30</b>	<b>TEA BREAK</b>
15:30-17:00	Counseling Role Play

**Day 4:**

08:00-8:15	Housekeeping
08:15-8:30	Review of Previous Days Work
08:30-10:00	Getting Started
<b>10:00-10:30</b>	<b>TEA BREAK</b>
10:30-11:30	Methods of Peer Outreach
11:30-13:00	Group Role Plays & Practice Sessions
<b>13:00-14:00</b>	<b>LUNCH</b>
14:00-15:00	Group Role Plays & Practice Sessions
<b>15:00-15:30</b>	<b>TEA BREAK</b>
15:30-17:00	Monitoring & Evaluation

**Day 5:**

08:00-8:30	Housekeeping
08:30-10:00	Design Implementation Plans
<b>10:00-10:30</b>	<b>TEA BREAK</b>
10:30-11:30	Conclusion & Course Evaluation
11:30-13:00	Closing Remarks & Presentation of Certificates
<b>13:00-14:00</b>	<b>LUNCH</b>

# **CHAPTER 1: WHAT DOES IT MEAN TO BE A PEER EDUCATOR?**

## **Facilitator Guide**

This introductory chapter serves to outline what a Peer Educator is including their roles and responsibilities.

### **Learning Objectives:**

By the end of the session, the peer educator will be able to:

- Define Peer Education
- Explain the objectives of Peer Education
- Identify qualities of a Peer Educator
- Explain the roles and responsibilities of a Peer Educator

### **Duration:**

90 minutes

### **Materials:**

Flip charts, paper, markers, chalkboard and chalk

### **Training methodology:**

Lecture and open discussion.

### **Lesson Plan:**

- Read the facilitators notes and go through the role-plays through before the session.
- Introduce topic and give brief explanation about Peer Education.
- Ask participants to take part in role-play.
- Divide participants into groups and let participants discuss role-play.
- Group report back.
- Facilitator gives overview of Peer Education.

### **Role-play:**

#### **Scene 1:**

Dr. Maluti 35-year-old consultant with an international organization that conducts training for Peer Education programs. Dr. Maluti is invited to conduct training with youth that are the children of Miners at a mining company. She is unable to speak the local language very well but tells them of her vast experience in training peer educators and how she wants them to execute the program in the local compound. Dr. Maluti then asks the youth to ask questions and give comments but the youth are silent. She is very frustrated with this lack of participation and shares this disappointment with them and leaves.

#### **Scene 2:**

Maekaeka is a parent peer educator with a local NGO. She is invited to a session on Parent-Child communication with a large firm that has a lot of elderly. After introducing the topic, Maekaeka asks the group to define what effective parent-child communication is, give ideas on how to achieve this and asks them to discuss what the most difficult aspects of parent-child communication are. Every participant is encouraged to talk and the session is very interactive and lively.

### **Discussion Points**

1. Which scene illustrates an effective Peer Educator and why?
2. What are the challenges that were faced by the peer educators in the two scenes?
3. Why did the participants react differently in the two scenes?
4. How can a peer educator create an environment where the participants actively participate in a session?

# CHAPTER 1: WHAT DOES IT MEAN TO BE A PEER EDUCATOR?

## Peer Educator Guide

Peer Education is a process of passing on information to people with similar characteristics i.e. age group, social status, economic status, education and cultural influences to influence behaviour.

Peer influence is very strong and can be negative or positive depending on the practiced behaviour. Peers share a lot of information be it bad or good. Peer education, therefore, seeks to empower peers with correct information on issues affecting everyone so that the information being shared can lead to the development of positive behaviours amongst the peers

### **Qualities of a Peer Educator**

#### *Personal motivation and ability to motivate others*

Peer Educators should have the ability to motivate others and make sessions interesting and lively. When this is done, the participants in the session will relax and contribute to the session.

#### *Being non-judgmental*

Peer educators should understand their feelings and beliefs about sexuality. It is critical that Peer Educators be able to talk about sexuality and sexual conduct without imposing their own values. This means that Peer Educators should learn to respect other individuals' views and opinions without being judgemental or condemning other people's actions.

#### *Being ethical and respecting confidentiality*

Peer educators need to keep information given to them as confidential as possible. This is very important if they are to gain trust and respect from their colleagues. Therefore, a Peer Educator needs to be honest and trustworthy.

#### *Being a role model*

Peer Educators need to lead by example. People learn new behaviours, attitudes and beliefs by watching and imitating others. In being a positive role model, Peer Educators gain respect and trust and their peers become more receptive to information that is being shared.

#### *Possess good communication skills*

Skills building constitutes an important element of Peer Education, as they need to be skilled in-group facilitation techniques, formal communication skills such as talks and presentations and informal discussion groups and case studies, which include the ability of role-playing. The sensitivity of the subject matter and complexity of the social and emotional barriers to sexuality require a skilled facilitator to manage the process. Facilitators work at stimulating discussion by encouraging trust, openness, two-way communication, asking open-ended questions and conducting focused activities.

### **Roles and Responsibilities of Peer Educators**

A Peer Educator has the role of reaching out to family, friends and the community including the workplace. The Peer Educator also has the responsibility of developing a program with realistic and specific goals. The Peer Educator identifies areas of concern, defines objectives of the program, creates a monitoring and evaluation plan and plans activities to be conducted. Creating a work plan for a specific period is essential for the program to be successful.

Behaviour change is a continuous process because individuals develop their character and behaviour slowly and changing that behaviour requires an investment of ample time. Individuals need time to appreciate their behaviour, examine options available, and make a choice to change behaviour based on the costs involved. The costs of behaviour change can be financial, emotional or social. An important element of behaviour change is support for modifying behaviour and Peer Educators need to help facilitate change in behaviour through support.

### **Who can become a peer educator?**

Management, with the help of co-workers, normally choose Peer Educators. Those selected should possess the qualities outlined above. One becomes a peer educator because they care. It means taking up responsibility to show you really care about the health and happiness of those around you. A peer educator should be:

- responsible
- well-motivated to help others
- a role model
- respectable
- understanding and should have good communication skills

### **Benefits of Peer Education**

Peer educators can encourage a working environment where co-workers can discuss their lifestyles and concerns freely. By being open with them and sharing information about HIV/AIDS, peer educators can help co-workers make informed choices about their behaviour. Although this might mean more work, there is also the personal satisfaction that one gains from knowing that you have helped co-workers, family and friends to prevent HIV infection and to encourage those infected to live positively.

Other responsibilities of a peer educator:

- Work closely with other peer educators in the workplace to coordinate efforts and avoid duplication
- Develop a peer educator plan. This plan outlines what activities you will be involved in e.g. making presentations, holding discussion groups, giving talks, showing videos, distributing condoms, making available reading materials and placing of posters, counselling.
- Monitoring and evaluation is also necessary to see whether or not the prevention programme is achieving its goals.
- Report writing

### **Methods of communicating to peers**

#### *Talks and presentations*

This is an effective way to provide information that deals with facts such as “How to prevent HIV/AIDS transmission” which can be found in Chapter 8.

#### *Informal discussion groups*

This involves small group discussions. The groups should not have more than 10-12 participants. The peer educator, being the facilitator, directs the discussion and controls the issues raised. You should encourage everyone to listen and respect what others are saying during a group meeting.

#### *One-to-one counselling*

This involves talking with a peer about their concerns and guiding them through their issue. Please refer to Chapter 9 on basic counselling skills.

#### *Song*

These can be used to rally peers and set the tone of meetings.

#### *Demonstration*

You could provide demonstrations on how to use a condom or any other area of interest including demonstrations on negotiating skills one can use for condom use or abstinence negotiation.

#### *Case studies*

Case studies are short studies, which focus on a particular incident or situation. This then forms the basis for discussion.

#### *Role-playing*

This requires members of the group to act out a particular situation or problem. Role-plays tend to be more effective when people take on roles different from their real life situations.

#### *Drama*

Drama provides information in an entertaining manner. It is easy to understand and drama performances should be used to introduce discussions.

# **CHAPTER 2: WORKPLACE ISSUES**

## **Facilitator Guide**

There are several issues relating to HIV/AIDS issues in the workplace, which should be done in conjunction with a Peer Educator to help employees raise their concerns. These include having an HIV/AIDS policy for the workplace, any HIV/AIDS concerns of employers and the subsequent role of a peer education programme.

### **Learning Objectives:**

By the end of the session, the peer educator will:

- Understand the importance of the existence of a HIV/AIDS policy document in the workplace
- Appreciate HIV issues and concerns for both employers and employees
- Know the rights of employees/employers within the work place
- Understand the role of a peer education programme in the context of an HIV/AIDS programme in the workplace
- Know how to approach and reduce stigma and discrimination in the workplace
- How to involve trade unions

### **Duration:**

45 minutes. Additional time may be required if the video is used

### **Materials:**

Flip charts. Video ('It's Not Easy' by Media for Development Trust – addresses stigma in the workplace).

### **Training methodology:**

Open discussion. Discussion on issues raised in video if used. One-minute role-play.

### **Role-play:**

A manager is interviewing a nervous young woman for a job. The man says musingly, 'your qualifications aren't outstanding and you don't have work experience'. He looks at her meaningfully. She says nothing. He says, 'what can you offer to convince me to give you the job?' She looks uncertain. Impatiently he says, 'most women would do anything for this job'. She looks down. He says, 'you are stupid, you don't understand, let me spell it out. You can have the job if you go to bed with me'.

### **Discussion Points:**

1. How would you handle this situation?
2. Is the manager's behaviour legal?
3. What can you say to get around the issue but still get the job?

## **CHAPTER 2: WORKPLACE ISSUES**

### **Peer Educator Guide**

1. Employees should be made aware that for the vast majority of occupations, the work place does not pose a risk of contracting HIV. The exceptions include laboratory workers, health care workers, persons dealing with hospital waste products, or any work which involves exposure to blood or blood products. Their risk is very low – but real.
2. Pre-employment HIV testing as part of fitness screening is unnecessary and should not be required. Nor should job applicants be obliged to disclose their HIV status or state whether or not testing has been carried out previously. HIV infection, does not, in itself, constitute a lack of fitness to work. If the job applicant is required to travel to a country where HIV testing is needed for residence, he/she should be advised of this before taking up the post. HIV infection alone does not limit fitness to work. If fitness to work is impaired by HIV related illness, alternative working arrangements should be made.
3. Persons in employment should not be screened for HIV. Nor should employees be obliged to inform management about their HIV/AIDS status. All medical information, including HIV/AIDS status must be kept confidential.
4. Employees infected with HIV should not be discriminated against with respect to their access to and receipt of in-service training, allowances, and occupational health schemes.
5. HIV infection is not a cause for termination of employment. As with many other illnesses, persons with HIV-related illnesses should be allowed to work for as long as they are medically fit for available, appropriate work.
6. Employees have a responsibility to adopt behaviour that does not put others in the work place at risk of infection.
7. Persons in the work place who are HIV infected (or perceived to be) must be protected from stigmatisation and discrimination by co-workers, unions, employers and clients. Employees should be encouraged to find out their employer's personnel policy on HIV/AIDS to understand their rights. Work place peer education programmes are essential to ensure this protection.
8. Employees should encourage management to provide access to condoms in the workplace. Access should be free, simple and discreet.
9. Employees should have access to voluntary counselling and testing (VCT) services and time off work to attend for testing and counselling.
10. Trade union representatives should be made aware of HIV/AIDS peer education programmes within the work place, and be provided with regular feedback on progress. Trade unions can assist in raising sensitive issues with management, and so it is important that good relations are maintained.

## **CHAPTER 3: VALUES: Their Sources & Influences**

### **Facilitator Guide**

The purpose of this session is to introduce and define the concept of values. The session assists participants in explaining their personal values and examines the relationship between values, attitudes and behaviour. **Throughout this session it is important to be aware of your own values and not let them influence the flow of the session.**

#### **Learning Objectives:**

By the end of this session, peer educators should be able to:

- Define values
- Identify different values & explore their sources
- Discover important values at a personal level
- Examine the difference between values, attitudes and behaviour
- Practice communicating values to others
- Practice accepting other peoples values.

#### **Duration:**

60 minutes

#### **Materials:**

Markers, cards marked “agree, disagree, not sure”, value sheets

#### **Training Methodology:**

- Write the word “value” on a flipchart or blackboard and ask for things that are valuable, note the things that are valuable but cannot be seen.
- Define Values, Attitude, and behaviour through brainstorming and clarify where necessary.
- Ask the participants to list examples of values.
- Ask each person write down their values which include things you believe in and are willing to stand up for, values which guide your behaviour. Ask participants to think of guiding principles learned from their families, traditions, cultures and religion that have influenced their behaviour.
- Do a values clarification exercise which will help participants identify their own values by “agree’, ‘disagree’, and ‘I don’t know.’
- Ask the group to brainstorm on the sources of values and list them.
- Divide the group in four groups and give each group two sources for them to work out the kind of values which come from each source.

Plenary:

- Groups report back on their work
- Draw a tree on the board. Have the values as the branches and the sources of values roots, have some of the fruits of the values as vices and positive behaviours.

#### **Exercise:**

Distribute to the participants several statements and questions. Each statement reflects a value, and the question reflects a behaviour that supports or ignores a value. For example:

1. I believe that condom use encourages promiscuity.
2. It is immoral for married men to have extramarital affairs
3. Should abortion be made more assessable to reduce mortality rate due to unsafe abortions?
4. Should condoms be provided to youth in schools?

Ask them to go through them individually and write down their responses on a piece of paper. . When everyone is done, ask for volunteers to discuss the responses or comments.

Some discussion points.

- How does it feel to stand up for your values when friends disagree with your values?
- What if your behaviour is not in line with your family, or religious values?

- What influences people to behave in ways that are consistent/inconsistent with their values?
- Do your values change, as you grow older? If your values and behaviour are different, which should you look at, your values or behaviour?

## **CHAPTER 3: VALUES: Their Sources & Influences**

### **Peer Educator Guide**

Values are those qualities, principles, beliefs and ideas we feel strongly about. People have different values. People make decisions based on their values and they feel happy about their decisions, but those who make decisions which are in conflict with their values feel unhappy about it and tend to regret it. It is important to make life decisions and live life according to personal values.

You will be asked about your own values related to various to the topics. It is appropriate to share some of your personal values that you learned from your family, or those that helped you make positive decisions about vocational goals and education

Our values influence the decisions we make and the behaviours we engage in although we may not always be conscious or aware of them.

In order for a belief to be considered a value, it must:

- Be freely chosen
- Chosen from a number of alternatives
- Acted upon
- Publicly affirmed

Values are shaped through a system of trial and error; one comes to establish a system of values which guides personal choices and behaviours. Parents and elders and key socializing institutions tell us what is right and wrong and enforce behaviours in accordance with those values. The media and other sources of popular culture also can set standards and model values in ways that are captivating to many people, young and old alike

The things, ideas, beliefs and principles that we hold dear to us shape our values. Our values help to define who we are and help determine our behaviour. For example:

- A man who values his family is likely to care about his wife, children and home life.
- A person who values health will likely have healthy life styles and healthy behaviours.
- A person who values education is likely to study hard for exams.

Each person can have different values coming from different sources including family, religion, and other sources.

Some family values:

- Doing well in school, and staying in school
- Going to discos or dances
- Using alcohol or other drugs
- Having children before marriage
- Remaining a virgin until marriage
- Helping with family chores
- Helping neighbours
- Attending church
- Your being male or female
- Getting married
- Making money, your friends and peers, and obedience.

# **CHAPTER 4: BEHAVIOUR CHANGE COMMUNICATION**

## **Facilitator Guide**

### **Learning Objectives:**

By the end of the session, the peer educator will be able to:

- Define behaviour
- Identify factors influencing individual behaviour change
- Explain the behaviour change process
- Identify the difference between attitude and behaviour
- Define communication and its role in behaviour
- Understand the decision making process.

### **Duration:**

45 minutes

### **Materials:**

Flip charts.

### **Training methodology:**

Open discussion.

### **Lesson Plan:**

1. Define the concepts in a brainstorm session: behaviour change, attitude, communication, behaviour and their differences.
2. Put them on news print
3. Give the working definition of BC
4. Divide participants in small groups and ask them to discuss the following:
  - a) Factors influencing behaviour- behaviour formation
  - b) Factors influencing behaviour change
  - c) Why people fail to change their behaviour
  - d) Role of communication in behaviour
5. Plenary; groups present followed by discussions.
6. Facilitator's input;
  - a) Give an input on all the above.
  - b) Discuss behaviour maintenance
  - c) Discuss the 5C's of Communication
  - d) Discuss decision making model
7. Summarise.

## **CHAPTER 4: BEHAVIOUR CHANGE COMMUNICATION (BCC)**

### **Peer Educator Guide**

Changing behaviors and attitudes is a process underlying changes in **Knowledge, Attitudes, and Practices** which take time. This opens new ideas and aspirations towards behavioral change. It can introduce new values or change the priorities of existing values, as these are the major factors which influence behavior formation and change.

**As the majority of your audience moves from one step to the next, they will need different messages and support.**

In addition to understanding the attitudes and behaviors of fellow peers, Peer Educators as communicators must have an understanding of the general dynamics of human behavioral change, a good formative research at the beginning helps to ensure that appropriate campaign strategies are adopted right from start. This includes knowledge of factors which stimulate people to change their behavior.

Use your knowledge of the behavior change process and information about fellow peers to think about the behavior changes you will encourage in your program.

**For Example:**

- No sexual activity
- Delay of sexual activity
- Mutual faithfulness
- Partner reduction
- Condom use with all partners
- Condom use with casual partners
- Ability to negotiate condom use
- Ability to talk to your partner about STDs/HIV/AIDS etc

What attitudes do you want to promote?

**Factors involved in Influencing individual behavior change**

A BCC strategy is one that speaks to the specific lifestyles and concerns of individuals in the target audience and reaches them where they are, targeting beliefs, values and attitudes. A combination of interpersonal and mass media are the most effective ways of influencing people's behavior and bringing about change in knowledge, attitudes and contributing to skills building.

Telling someone what to do is the least effective way to help an individual change.

<b>To help people change their behaviors a communicator needs to help people to:</b>
<ol style="list-style-type: none"><li>1. Reflect honestly on their behaviors and why they behave the way they do.</li><li>2. Review their own negative practices and replace them with positive ones</li><li>3. Develop positive attitudes about changing their behaviors.</li><li>4. Strengthen positive values and beliefs and help them make good decisions based on the positive values.</li><li>5. Build a stronger sense of self worth and self-esteem.</li><li>6. Build skills needed in order to assert themselves in sexual situations.</li><li>7. Feel loved, accepted and supported to adopt a new behavior.</li></ol>

**Stimuli to behavioral change**

- ❑ **Physical-** fear of pain and memory of past pain
- ❑ **Rational-** knowledge and reasoning, if people know the facts, they may choose to do the right thing
- ❑ **Emotional-** feelings – love, fear and hope
- ❑ **Skills-** Capacity to adopt the new behavior and to continue
- ❑ **Family and personal networks-** family and peer pressure
- ❑ **Social structures-** social economic, legal and technology

**Behavior Change Process**

Often people take a long time to change their behavior and to adopt a new behavior. It is unrealistic to assume that the entire target audience will be able to change from negative to positive attitudes and behaviors during one brief HIV/AIDS intervention.

Several things help people make changes they can sustain over a period of time.

- Personal commitment to make the desired changes. (*I think this change is a good idea and I want to try it.*)
- Acquiring the skills to implement the changes. (*I have the ability to negotiate condom use with partners.*)
- Creation of a supportive environment in which to practice and make the new changes. (*I have friends who use condoms and think using condoms is a smart idea.*)

**Steps to Behavior Change Management**

**1. Knowledge**

Recalls specific messages  
Understands what messages mean

**2. Approval**

Responds favorably to messages  
Discusses messages or issues with members of the networks  
Thinks family, friends, and community approve of practice

**3. Intention**

Recognizes that specified health practices can meet a personal need  
Have a favorable attitude towards the desired behavior  
Intends to utilize the services at some time.

**4. Practice**

Acquire the information, products and skills necessary to practice the skills behavior.  
Change behavior using those products and applying those skills and practice the behavior regularly.

**5. Confirmation/advocacy**

Recognize the advantages of changed behavior, integrate the new behavior into normal lifestyle and promote new behavior among others

The process of changing behaviors and attitude is not a direct journey. People move back and forth between steps before achieving success.

**Example of moving a person through the behavior change process:**

---

**STD Example**

Awareness	Tell them that sexually transmitted diseases (STDs) exist and can be dangerous to their health and their partners. They should know how to identify it and prevent it. Give them information to help them know whether they have an STI. Tell them where to go and what would happen if they don't
Acquiring skills and knowledge	Encourage them to visit a clinic if they think they have an STD tell them where the clinic is. Tell them its treatable once diagnosed early.

---

Motivation	Encourage them to use condoms with all partners to prevent further infections. Encourage them to take all the drugs given properly.
Motivation to trial	Tell them to use condoms with each partner
Trial to success	Tell them they did the right thing by going to the clinic. Encourage them to come again. Congratulate them for using condoms with their partners and remind them to continue using condoms.

**Developing Successful Messages**

*Identifying the benefits:* If you choose condoms your wife will be protected from STDs

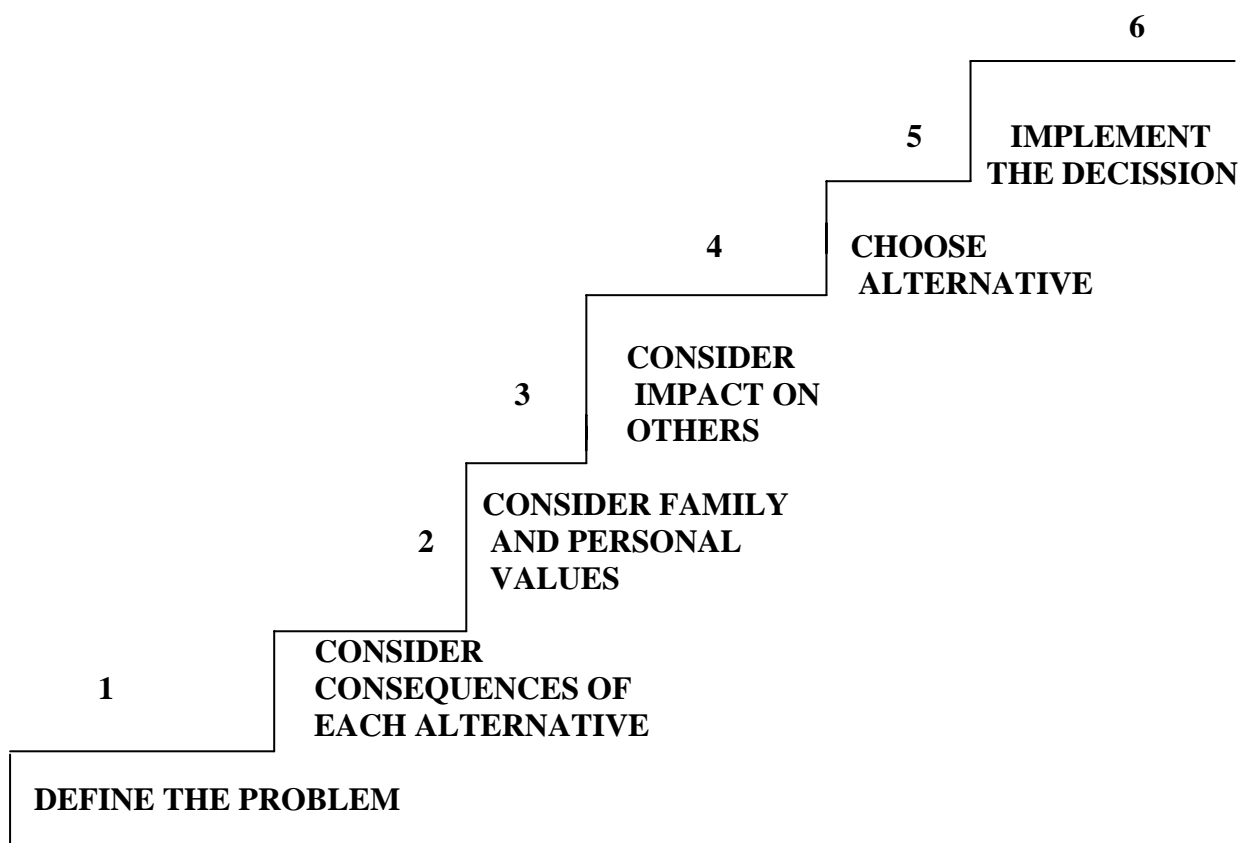
*Support the benefits with relevant information:* STDs can cause infertility in men and women and harm children

*Make the messages clear and simple:* Safe sex it is easier than you think

*Highlight points:* Get your condoms today; regular use of condoms prevents the spread of disease; love alone will not protect your life; love each other enough to use condoms.

*Find credible sources to deliver your information:* This helps people to accept the information if they have faith in its source.

**DECISION MAKING MODEL:**



**Important Idea # 1: Most people try to do what their peers and friends are doing.**

One predictor of a person’s actual behaviour or actions is what they think their friends are doing. People model behaviour on what they see others doing. In changing people’s behaviours, let you peers know that other people, people like them, have already begun to make changes. People need to hear these types of stories before they themselves can change.

**Important Idea # 2: Fear can often stop people from making a change. They need to find solutions to the problem.**

If someone is afraid and they don't believe there is a solution, they will not change their behaviour. They may instead go into denial that there is a risk. We have learned that simply telling someone that HIV/AIDS can kill him or her can actually stop someone from making a change. People also need to hear a solution. They need to believe that the solution can work for them before they can make a change.

**Important Idea # 3: People must believe that they personally are at risk before will they will change.**

It is natural for people to want to deny that they are at risk of a HIV and other health problems. As mentioned above, people are trying to deal with their fears and one way to deal with a fear is to pretend that the problem does not apply to them. Almost everyone wants to believe that it is only others that are at risk for HIV/AIDS but not themselves. As a peer educator, one can teach people about their true risks of HIV infection.

**Important Idea #4: People must believe there are benefits to changing their behaviour.**

For someone to make a change they must believe that the benefits will outweigh the negatives. When working with a group, have them list all the potential benefits and all the potential negatives or barriers to making a change and then have the group weigh the different potential decisions and benefits.

**Important Idea # 5: People must believe they have the capability to change behaviour.**

As a peer educator, one of the most important roles you have is to teach people new skills, not simply information. For example, maybe you are trying to convince a young man that he needs to use condoms with his girlfriend. He says, "No, I couldn't. How would I bring it up? She would leave me." You should encourage him to have a practice conversation with you. Give him some ideas for the words he must say. In the case of HIV/AIDS you can ask the following questions:

- Have you heard of HIV/AIDS?
- Are you worried about HIV/AIDS in your life? Do you think it can affect you personally?
- Have you started to make any changes to avoid HIV/AIDS? What are they?
- Do you know what you need to know/do? How has it been going? What skills do you need?
- What do you need to keep using condoms/having fewer sexual partners? What have your problems been? What are you going to do now?

In summary, a Peer Educator should be able to:

- Emphasize risk
- Emphasize benefits
- Address barriers
- Teach concrete steps
- Reinforce messages

# **CHAPTER 5: REPRODUCTIVE HEALTH**

## **Facilitator Guide**

### **Learning Objectives:**

By the end of the session, the peer educator will be able to:

- Clearly define Reproductive Health
- Identify components of Reproductive Health
- Identify myths and misconceptions in Reproductive Health
- Describe the factors affecting Reproductive Health in Zambia

### **Duration:**

45 minutes

### **Materials:**

Flip charts.

### **Training methodology:**

Lecture on the various elements of reproductive health.

# CHAPTER 5: REPRODUCTIVE HEALTH OVERVIEW

## Peer Educator Guide

Reproductive Health sets the stage for health beyond the reproductive years for both women and men. Girls and women are greatly affected because they often have no control over their sexuality and fertility. They bear the greatest burden of reproductive health problems. They are at risk from pregnancy, childbirth and related complications. They are also exposed to contracting infections including sexually transmitted diseases and HIV/AIDS.

Social, economic, and cultural factors have a negative effect on the reproductive health of an individual. These factors can be due to gender imbalances between men and women, poverty or cultural practices such as widow cleansing. Healthy and safe human sexual relationships directly affect the ability of young people and adults – both men and women to maintain good reproductive health.

With regard to women, reproductive health is much more than an approach to family planning as it ensures a life cycle approach to reproductive health needs starting before the start of a girl's menstrual cycle and continuing after menopause. This approach relies on holistic and integrated solutions that take into account the social, biological, as well as psychological causes of reproductive ill health. Thus, reproductive health enhances women with information that enables them to know their bodies to then improve the prevention and management of reproductive and other health problems and ultimately gain more control over their fertility and sexuality.

It also seeks to expand women's empowerment by creating enabling conditions for them to participate in national development; addresses the issue of men's role/needs in reproduction and of their responsibilities in the area of reproduction and sexuality; provides basic health services especially those which prevent maternal morbidity and mortality.

### Components of Reproductive Health

- Safe Motherhood
- Family Planning
- Sexually Transmitted Diseases /HIV/AIDS
- Sexual and Reproductive Rights
- Male involvement in Reproductive Health
- Abortion

### Factors affecting Reproductive Health

The factors affecting reproductive health and its attainment are not limited to the interventions by the health sector alone. Reproductive health affects and is affected by, the broader context of people's lives. These include economic, education, employment, living conditions, family, environment, social and gender relationships, and traditional and legal structures. Sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors.

Others include:

- Inadequate RH Services
- Inadequate infrastructure for RH
- Poor referral system
- Inadequate skilled personnel
- Inadequate information for the young and the aged on RH
- Harmful social cultural practices.

Effects of Inadequate Reproductive Health Provision contribute to high maternal morbidity and mortality rates due to:

1. HIV/AIDS and STDs (mode of transmission, management and prevention)
2. Unsafe abortions
3. Frequent pregnancies

4. Early child bearing
5. High fertility rates
6. Low male involvement in RH
7. Teenage pregnancies
8. Unsafe deliveries
9. High Infant and child morbidity and mortality

#### **Possible interventions to ensure safe motherhood**

- Enlighten the community on the risk factors of pregnancy such as too many children, poor nutrition, low social status
- Provide information to mothers on their reproductive health and rights, and utilization of health services
- Provide quality reproductive health services at community level such as emergency obstetric care in cases of high risk pregnancies
- Provide information on community based family planning services
- Improve the referral system
- Provide counseling

It is expected that if these services are adequately provided and appropriate education is given to women, safe motherhood could be achieved. Men need to support maternal health and safe motherhood.

#### **Unmet needs in Family Planning**

- Quality of services/counseling for FP
- Accessibility of services
- Inconsistent supplies
- Counseling
- Quality of services for special groups e.g. youths, aged and men

#### **Adolescent Reproductive Health**

**Young people aged 10-24 are particularly vulnerable and yet underserved by most reproductive health programmes. They are poorly informed on how to prevent pregnancy, STDs and HIV/AIDS. Poverty and lack of education also contributes to the high rate of pregnancies and unsafe abortions in young people. Common reproductive health concerns of young people:**

- Unplanned pregnancy
- Unsafe abortions
- Menstrual irregularities and pre-menstrual syndromes
- STDs and HIV/AIDS.
- Early pregnancies leading to difficult deliveries
- Sexual abuse
- Puberty and its psychological effects

#### **Factors Affecting Adolescent Reproductive Health**

- Inadequate information on their bodies, puberty, sex, sexuality and reproductive health for adolescents
- Inaccessibility of youth friendly reproductive health services
- Provider non-responsiveness to young peoples problems
- Unskilled manpower for Youth Friendly Health Services
- Early marriages – Early pregnancies
- Social cultural and economic factors
- No one to talk to about these issues
- Misinformation from peers

#### **Male Involvement in Reproductive Health**

Men's commitment to their children is key to the quality of family life and prospects of the next generation, yet they have not taken up their share in family life. Their socialization has perpetuated myths about male sexuality, expectations about sexuality and masculinity and acceptance of domestic violence. Men often consider sexual and reproductive health matters to be women's concerns. Some concerns for men include:

- HIV/AIDS and STDs
- Infertility
- Other sexual malfunctions

# CHAPTER 6: FAMILY PLANNING

## Facilitator Guide

### Learning Objectives:

By the end of the session, peer educators should be able to:

- Identify all available contraceptive methods and explain how they work;
- Cite the advantages and disadvantages/side effects of contraceptives;
- Accurately demonstrate the steps to male and female condom use, including storage and disposal;
- Identify and respond to specific concerns, myths and misconceptions related to family planning methods including condoms.

### Duration:

2 hours

### Materials:

Flip charts, markers, samples of contraceptives

### Training Methodology:

Lecture, open discussion

### Lesson Plan:

Read the case study to participants.

Discuss with the participants their understanding of the case study.

Case Study: Rodgers and Mutinta are a happily married couple with one child. Both of them work. Because of her hard work and dedication to duty, Mutinta has been offered a part time opportunity to further her studies for two years at a local college. This pleases both Rodgers and Mutinta although one thing bothers them...they do not want to have another baby at this time, as this would disturb Mutinta's studies. Yet at the same time, they still want to enjoy a happy sexual life as husband and wife.

### Discussion Points:

1. What advice would you give this couple and why?
2. If you were in the same situation, where would you go for advice in your community?
3. What would be an ideal ending to this scenario?
4. Whose responsibility is it to determine family size?
5. Who determines the method of family planning a couple should use?
6. What are some of the traditionally family planning methods still used in your community?

Divide them into small groups and ask them to:

- List the family planning methods they know;
- Cite the advantages and disadvantages of each method they list

### Plenary:

Allow each group to present their work.

Discuss and clarify any myths/misconceptions from the presentations.

Ask anyone from the group to volunteer to demonstrate condom use.

# CHAPTER 6: FAMILY PLANNING

## Peer Educator Guide

### **Traditional family planning practices in Zambia**

Traditional methods of family planning frequently involve the use of local herbs to regulate fertility. Traditional methods of birth control also include withdrawal, non-penetrative sex, enforced post-partum abstinence whereby couples abstain from sexual intercourse for a specific period after the mother has given birth.

Natural family planning refers to reversible methods of contraception that rely exclusively on harmonising sexual intercourse with the female fertility cycle to conceive or prevent conception. All methods of natural family planning are based on awareness of the natural signs and symptoms association with each phase of the women's menstrual cycle. For example, the rhythm method requires the charting and recording of each menstrual period.

Advantages include: No adverse side effects; Involves both partners; No cost. Disadvantages include: Risk of pregnancy; no protection against STIs including HIV/AIDS.

### **Barrier Methods**

#### **Male Condom**

The male condom is a sheath of latex that fits over the penis like a second skin. It catches and holds the semen released during ejaculation, thereby blocking sperm entry to the vagina. Most latex condoms are coated with a lubricant that reduces the risk of breakage. Some brands also add nonoxynol 9, an ingredient that kills sperm and many types of germs. **They protect against sexually transmitted diseases (STDs), including HIV/AIDS with an efficacy of 88-98%.**

#### **CONDOM DEMONSTRATION--How to Use a Male Condom**

Advantages include: Protects against STDs including HIV/AIDS; One size fits all; Easily available; Inexpensive or even free. Disadvantages include: Must be used every time a couple has sex; For some, reduced sensitivity and decreased pleasure; embarrassment around initiating condom use; Breakage. In practice, condoms, when used consistently and correctly can be 97% effective.

#### **The Female Condom**

The female condom is a thin, loose-fitting polyurethane (plastic) sheath with two flexible plastic rings on either end and is used by women for insertion. It is closed at one end and provides a physical barrier that lines the entire vagina. Like a male condom, it is intended for one-time use and is pre-lubricated. It can, however, be inserted up to 8 hours before sexual intercourse.

#### **CONDOM DEMONSTRATION--How to Use a Female Condom:**

Advantages include: Protects against STDs and HIV/AIDS; no side effects. Disadvantages include: Relatively expensive; bulky; can be difficult to insert.

#### **Vaginal Spermicides: Foaming Tablets and Contraceptive Foam**

The foaming tablet and contraceptive foam are spermicidal products which prevent conception by killing sperm. These products require insertion into the vagina before sex. Advantages include: Easy to use; are widely available; provides some protection against sexually transmitted infections. Disadvantages include: Possible allergy to spermicide; insertion requires precision; protection is short-lived; messy; cultural preference for dry sex.

#### **Oral Contraceptives: Birth Control Pills (Microgynon, Microlut, Eugynon, Safeplan)**

Oral contraceptives, through the combined action of hormones, prevent pregnancy by temporarily stopping ovulation and thickening the cervical mucus. Each day, the woman takes one pill from a pre-packed series of tablets. As long as the woman sticks to her pill-taking schedule, ovulation will not occur.

Advantages include: Highly effective; safe for most women; regulates menstruation and decreases cramps; Easy to use; Protective effect against many cancers. Disadvantages include: No protection against HIV/STDs; must be taken daily; possible side effects include nausea, headaches or breakthrough bleeding for some women.

### **Injectables: Depo-Provera & Noristerat**

Injectables are injections that prevent pregnancy through hormonal action and are long acting. The two most widely used are Depo-Provera and Noristerat. They contain the hormone progestin which prevents pregnancy by stopping ovulation. Depo-Provera is administered every 3 months and Noristerat every 2 months.

Advantages include: No daily activity required; Offers privacy to user. Disadvantages include: Menstruation can become light and irregular or stop; no protection against HIV or STDs; Requires ongoing clinic visits; Cannot be reversed until the body has used up the injected amount of the hormone (sometimes takes a few months).

### **Implants: Norplant**

Norplant is a set of 6 tiny capsules, each containing progesterone. They are implanted by a doctor or specially training nurse just under the skin on the inside of a woman's upper arm and are long-lasting. The tubes are invisible after insertion. Norplant offers 5 years of effective contraceptive if left in place.

Advantages include: long-lasting protection; no attention after it is inserted, is reversible. Disadvantages include: Irregular bleeding and spotting; no protection against HIV or STDs; requires minor surgery for insertion and removal; Expensive; Norplant must be inserted and removed by a trained practitioner.

### **Intrauterine Devices (IUDs): Copper T**

The Copper T has a thin copper wire wrapped around the stem and is in the shape of a T. An IUD is placed in a woman's uterus by a physician or specially training nurse and is effective for up to 10 years. IUDs come in assorted shapes sizes.

Advantages include: Long-lasting and reversible; inexpensive. Disadvantages include: No protection from HIV or STDs; 2-10% IUD users spontaneously expel the device within the first year; requires a medical examination.

### **Sterilization: Permanent methods**

#### **Tubal Ligation**

A tubal ligation is a permanent method of family planning. It is a simple operation for women in which the fallopian tubes are cut and tied so sperm cannot reach the egg. Since the operation does not affect hormone production, it has no effect on sexual desire.

#### **Vasectomy**

A permanent method of family planning for men. A man will enjoy their normal sexual life but will not be able to make a woman pregnant as all they will ejaculate is seminal fluid without sperm cells. Advantages include: Highly effective; Permanent. Disadvantages include: Does not protect against HIV/STIs; Only specially equipped facilities and highly skilled personnel can offer the service. Some people may have to travel far to access the procedure.

### **Emergency Contraception: Postinor –2**

Emergency contraception refers to methods that prevent pregnancy after unprotected sex. These methods are generally reserved for emergencies like rape, a broken condom or other situations that place a woman at risk of unintended pregnancy. It is not intended for routine family planning. Emergency contraception must be initiated within 3-5 days after unprotected sex.

The most common method of emergency contraception is emergency contraceptive pills (ECPs). Also called the 'morning after' pill. Postinor-2 is one type of ECP available in Zambia. ECPs are given in two doses, the first of which must occur within 72 hours of unprotected sex. ECPs block fertilisation and implantation; they do not induce abortion.

Advantages include: Easy to use; Only method which can be used after unprotected sexual intercourse; Minimal medical risks. Disadvantages include: Not as effective as other contraceptive methods; nausea, vomiting; no protection against HIV or STDs.

# CHAPTER 7: SEXUALLY TRANSMITTED DISEASES (STDs)

## Facilitator Guide

STDs, including HIV/AIDS, have a devastating effect. Part of the important work of the Peer Educator is to help their colleagues understand what treatment is available for STDs and perhaps more importantly what they can do to prevent them.

### Learning Objectives:

Upon completion of this session, participants will be able to:

- Define STDs.
- Counsel and teach clients about STDs.
- Explain the transmission of STDs.
- Explain the prevention of STDs.
- Identify wrong perceptions about STDs and correct them.
- Identify signs and symptoms of common STDs

### Materials needed:

Flip chart paper and markers.

### Duration:

90 minutes

### Training Methodology:

Lecture

Open Discussion

### Lesson Plan:

- Explain that you would like to start by finding out what the people think STDs are. Let the participants answer these questions. They should list down all the responses. Discuss these findings as a group and come up with one table reflecting things that the groups have agreed on together. Discuss further on those which they have doubts about with reasons why they doubt it.
- Take note of strong feelings on findings when they don't agree as a group. Let them compare each response on the group list with those given in their handbook. Let them cross out what is not in the handbook
- Explain that these diseases can be grouped together according to the signs they present and that these signs can be seen on the genital parts of both male and females. You should use some visual aids such as slides on STDs or picture codes with STDs for them to see. Let them say what they see on the slides or pictures and discuss briefly among themselves whether they often see these things

STD visual aids must be shown showing different types of STDs and their signs. The participants can be broken into small groups to identify common STDs in their localities and discuss them. The facilitator can then clarify.

## **CHAPTER 7: SEXUALLY TRANSMITTED DISEASES (STDs)**

### **Peer Educator Guide**

#### **Definition**

Sexually Transmitted Infections (STDs) are contracted through sexual intercourse from an infected partner to non-infected one. Some STDs are passed on from a pregnant woman to her child before birth or during birth. Gonorrhoea, Syphilis, Chancroid and HIV/AIDS are the most commonly transmitted STDs.

Patients usually have some of the following signs and symptoms.

- Sores or ulcers on either the vagina or the penis.
- Pus discharge from either the penis or the vagina.
- Pain in the lower abdomen or scrotum.
- Swelling in either both or one groin (commonly referred to as Bola Bola).
- Pain on passing urine.

#### **Size of the problem**

About 10% of adult outpatient visits in Zambia are due to STDs. The full extent of the problem is hidden, however, because many people seek treatment from informal health care providers such as traditional healers or drug vendors. Surveys in antenatal clinics in Zambia have shown that 10% - 15% of expectant mothers have Syphilis antibodies. STDs produce great hardship through complications such as infertility, abortion and cervical cancer. They also cause painful and disfiguring genital wounds. STDs can also be transmitted from an infected pregnant mother to her baby. The baby may be born with Syphilis and pus discharge, or even HIV/AIDS.

#### **STDs and HIV transmission**

A person with an STD such as Syphilis or Chancroid is more susceptible to infection with HIV. Research has demonstrated that prevention and control of STDs helps in prevention and control of HIV. Further discussion on HIV/AIDS can be found in Chapter 8.

#### **Antibiotic Resistance**

More than half of gonorrhoea strains are now resistant to penicillin. This means that penicillin, which is inexpensive, should no longer be used to treat this disease. A smaller percentage (1% - 5%) of gonorrhoea strains are also resistant to some other potent drugs. Chancroid is also becoming resistant to most antibiotics including septin, which used to be the drug of first choice. The problem of drug resistance is made worse by the use of antibiotics in sub-standard doses bought from drug vendors without proper prescription.

#### **Preventative Interventions**

For proper control of STDs, persons with symptoms must be correctly diagnosed, appropriately treated and given advice on protection against further transmission and future acquisition of additional STDs. Their sexual partners should also be screened for infection and appropriately treated and counselled.

Peer Educators should discuss STDs:

- To promote and reinforce safer sexual practices;
- To correct any misconceptions and provide factual information about STDs;
- To discourage use of antibiotics without proper diagnosis and prescription.

### **The 5 C's for communication on STDs**

**Counselling** on the dangers of STDs, the importance of having only one sexual partner and the process of STD care.

**Confidentiality** - Privacy is essential for effective counselling. Organize your consulting area to permit confidential discussions. Information regarding the patient should not be communicated to other persons without consent of the patient.

**Compliance with treatment** -- Emphasize the dangers of defaulting while on treatment.

**Contacts** - Treatment of sexual contacts is crucial. Patients should be encouraged to bring all of their sexual contacts for the same treatment whether or not the contacts have symptoms.

**Condoms** – They should be used until both partners complete treatment and for those who choose not to abstain. Even persons who are limiting their sexual partners will benefit from condoms--one partner might have an infection and not know it.

### **Genital Ulcer Syndrome**

#### **Description**

- In males, ulcers are commonly found on the penis, though they may appear anywhere on the external genitalia.
- In females, ulcers can develop on the external genitalia, at the vaginal opening, inside the vagina or on the cervix.
- These ulcers may appear with or without swelling and drainage from bubos (infected glands in the groin).
- Herpes types 1 and 2 cause small blisters on the genitals.
- Warts on the genitals

What the Peer Educator should do:

- Counsel the patient (see *The five C's for communication about STDs*)
- Refer the patient to a health centre or the clinic at your workplace, if you have one.

#### Types of Genital Ulcers

- Syphilis often causes ulcers that are painless, clean, single and do not bleed easily when pressed. Without treatment these ulcers may heal in 4-8 weeks, but the deadly disease remains.
- Chancroid often causes ulcers, which are painful, dirty, multiple and bleed easily when pressed. Patients often develop enlarged lymph nodes in the groin called bubos (commonly known as Bola Bola), which may become tender and soft and drain pus.
- Lymphogranuloma venereum (LGV) also often causes ulcers, draining bubos and sometimes swelling of the genitals.
- Granuloma inguinale often causes lumps under the skin in the genital region. The lumps break down to become “beefy”, red, painless ulcers without lymph node enlargement.
- Herpes causes itchiness, then small blisters that turn into small, shallow, painful ulcers on the genitals. Ulcers heal on their own in 2-3 weeks and in 50% of persons the ulcers return periodically even without further sexual exposure.
- Some also cause cauliflower shaped warts on the genitals. The disease is caused by a virus that also causes cancer of the cervix.

*It is quite difficult to reliably distinguish between the ulcers caused by syphilis, Chancroid, LGV and granuloma inguinale on clinical examination alone, without laboratory investigations.*

### **Genital Discharge Syndrome (STDs that show discharge from penis or vagina)**

### **Description**

- In males, there is pus dripping from the penis and there may be burning pain when passing urine. If the genital discharge is not treated the patient develops complications including infection of the testes and infertility.
- In females, symptoms may be absent during early infection (up to 25% of the time) or there may be pus vaginal discharge. Complications of the infection that develop later include infertility and infection of a baby's eyes during birth that can lead to blindness.
- In females, diagnosis of the syndrome is complicated by the fact that vaginal discharge may also be caused by other infections.

What the Peer Educator should do:

- Counsel the patient (see *The five C's for communication about STDs*)
- Refer the patient if the symptoms do not improve.

### **Lower Abdominal Pain or Scrotal Pain**

If genital discharge (from either Gonorrhoea or Chlamydia) is left untreated then infected females may develop lower abdominal pain as a result of Pelvic Inflammatory Disease (PID). Similarly, infected, untreated males may develop pain in the scrotum.

### **Pelvic Inflammatory Disease (PID)**

PID is inflammation of the uterus and fallopian tubes usually as a result of infection with gonorrhoea, chlamydia or anaerobic bacteria. Patients complain of lower abdominal pain, backache, pain on sexual intercourse and sometimes vaginal discharge. With acute PID there may be a fever.

### **Scrotal Pain**

This is severe inflammation of the testes as they are swollen and tender. Discharge from the penis may occur. Severe pain and sudden swelling of one or both of the testes is common.

### **STDs Affecting Newborn Infants**

Infants born to mothers with untreated gonorrhoea or syphilis can develop congenital syphilis or pus discharge from the eyes. The baby may appear completely normal at birth or, if severely infected, may have signs.

### **Signs and Symptoms in a baby:**

- Skin rash -- various appearances.
- Distended abdomen due to liver and spleen enlargement
- Blood stained nasal discharge with nasal obstruction
- Joint swelling.
- Various non-specific signs: anaemia, jaundice, etc

### **5C's of Communication:**

- **Condom promotion**
- **Contact tracing**
- **Compliance**
- **Counselling**
- **Confidentiality**

# CHAPTER 8: HIV/AIDS

## Facilitator Guide

Zambia has one of the highest HIV/AIDS prevalence rates in the world; 19.7% of the adult population 15-49 years is infected. HIV/AIDS affects productive members of society and thus workplace plays a important role in providing HIV/AIDS education, prevention and support to those infected or affected with HIV/AIDS.

### Learning Objectives:

By the end of the session, the peer educator will be able to:

- Define HIV/AIDS and identify the modes of transmission.
- Explain myths and misconceptions about HIV
- Explain prevention methods.
- Explain why HIV Voluntary Counselling and Testing (VCT) is important.

### Duration:

2 Hours.

### Materials:

Flip Chart, markers

### Training Methodology:

Lecture, Open discussion.

### Exercise:

Divide the group into small groups and ask them to answer the following questions-

- 1) Are HIV and AIDS the same, why or why not?
- 2) Can mosquitoes spread HIV?
- 3) Can you get HIV from kissing?
- 4) You can catch an STD or HIV through only one unprotected sexual act.
- 5) Will condoms protect you from HIV/AIDS?
- 6) Can you tell if somebody is HIV positive by looking at them?
- 7) You can get HIV from sharing food or a toothbrush with somebody that is HIV positive.
- 8) Explain the modes of transmission and prevention.
- 9) What is VCT and its advantages/constraints?
- 10) Is there a cure for HIV/AIDS?

### Plenary:

- Allow each group to present their work.
- Discuss and clarify any myths/misconceptions from the presentation.
- Discuss high, low and no risk behaviours through a personal risk assessment.

## **CHAPTER 8: HIV/AIDS**

### **Peer Educator Guide**

#### **What is HIV?**

The letters HIV stand for Human Immunodeficiency Virus.

HIV is a strong virus that can get into your body through body fluids of another person who is already infected with the virus. The virus slowly damages the body's immune system which fights off infections. HIV can spread through any of the following fluids: blood, sperm, vaginal fluids—into the skin of another person. HIV can be transmitted through:

- Un-protected sexual intercourse (having intercourse without a condom)
- Blood contact
- An infected mother to her baby during pregnancy, delivery and / or breast-feeding (Mother to Child Transmission –MTCT).

A large percentage of the Zambian population aged 15-49 years is infected with the virus.

- The prevalence rate is higher in urban areas and lower in rural areas.
- More women are infected with HIV than men.
- The ages of highest infection are 20-29 and 30-39 among women and men respectively.

#### **Transmission through un-protected sexual intercourse**

This happens when two people (man and woman /man and man) have sexual intercourse without using a condom. This is the most common way that HIV is transmitted in Zambia. The virus is more concentrated in body fluids such as semen from men, vaginal fluids from women, and blood from both. Although there is evidence of the virus in saliva, the quantity is so minimal that it is not regarded as dangerous. Every un-protected sexual act is a risky act unless both partners have confirmed through an HIV test that they are not infected. Practicing dry sex or anal intercourse may increase the risk of transmission.

#### **Blood Transfusion/Contact with blood**

Getting a blood transfusion with infected blood is another source of transmission. If instruments contaminated either with blood or other body fluids have not been sterilized, the virus can be passed on when used by another person.

#### **Mother To Child Transmission (MTCT)**

MTCT is the transmission of the virus from an infected mother to her child during pregnancy, delivery, at birth or through breastfeeding. It is by far the largest source of HIV infection in children below the age of 10 years. In Zambia, 30 to 40 percent of babies of HIV positive mothers are infected.

If you have the HIV virus in your body, you are HIV Positive. You will not feel sick immediately but it slowly and continuously begins to damage your immune system. You can look and feel fine for some time, even years when you have HIV in your body. This is why you cannot tell by looking if a person has the virus in their body or not. This stage is called the asymptomatic stage which simply means that there are no signs to show that you are sick.

#### **What is AIDS?**

The letters AIDS stand for Acquired Immune Deficiency Syndrome

As your immune system and your body grow weaker and weaker, at some point your body will lose the power to be able to fight diseases and sickness. This stage is called AIDS. There is no cure, at present for AIDS. There are some medicines available in some countries including Zambia that can delay the progress from HIV stage to AIDS. However, these are often expensive and not widely available.

## Myths of HIV

1. If you hug someone with AIDS you can acquire HIV
2. AIDS can be cured
3. Using someone's personal belongings like a comb or hair brush can spread HIV
4. You can tell by looking whether someone is HIV positive
5. If you give blood you are at risk of getting HIV
6. You can acquire HIV from a toilet seat
7. Female homosexuals don't have to worry about HIV
8. Birth control pills can prevent the transmission of HIV
9. Loyalty to a partner is 100% safe
10. If you kiss someone with HIV you will get the disease
12. People with HIV/AIDS have been immoral
13. Fat people can not have HIV/AIDS
14. Witchcraft causes HIV/AIDS.
15. Mosquitoes transmit HIV
16. Condoms break easily

## PREVENTION OF HIV/AIDS

In the absence of treatment or cure for AIDS we must look to prevention as our main hope for overcoming this fatal disease.

The development of a vaccine against HIV is an important objective for preventing the spread of infection. However, there are many technical problems in developing a vaccine against AIDS. There are several trials of vaccines in progress at present.

The following are some ways in which we can minimise the spread of HIV.

- Stick to one faithfully partner
- Use a condom correctly and consistently **each time** you have sex. Correct and consistent use of a condom offers 97% protection from contracting the HIV virus.
- Avoid having multiple sexual partners
- Avoid contact with blood and other bodily fluids such as semen and vaginal secretions
- Put on gloves before giving first aid. Don't use your teeth when removing or putting gloves on. Pull gloves off inside out. This keeps any contamination inside the gloves. Put the gloves in a plastic bag, seal it and put it in a rubbish bin, or incinerator

- Cover any cuts, chapped skin or open wounds with waterproof dressing.
- Wash hands or other skin surfaces immediately if you have been in contact with blood or other body fluids.
- Avoid using unsterilised needles/syringes
- Avoid sharing use of razor blades, needles and skin piercing equipment
- If you are a woman and have HIV you could pass the virus to your unborn baby. It is therefore important to consider carefully whether to get pregnant or not.
- When blood, vomit and stool drop on the floor, pour freshly prepared Jik solution on it. (Jik solution should be prepared using one part to three parts of water) After 15 minutes wipe out with a paper and throw in a pit latrine or toilet.
- Control and treat other sexually transmitted diseases
- Be in a position to communicate to others on HIV/AIDS
- Voluntary counselling and HIV testing
- Abstinence

## **VOLUNTARY COUNSELING & TESTING (VCT)**

### **Taking the test**

Feel free to share your concerns with a counsellor so he /she can answer your questions and tell you how the test is done during the pre-test counselling session. A blood sample is then taken. The counsellor will then talk to you again and explain the result. The counsellor will only reveal the results to you and anyone you have chosen to bring with you to the post-test counselling session. Your results are strictly confidential. Telling your family, friends and workplace is your choice.

### **What do you do if the result is negative?**

A negative result means that either:

- 1) Right now you are not infected with the HIV virus, or
- 2) You have been infected but it is too early to detect the virus. It can take 3-6 months (the 'window period') to test positive after being infected with HIV.

### **What do you do if the test is positive?**

A positive result means that you have been infected with the HIV virus. It is very important to avoid infections and keep your body healthy. This also means that you should avoid being re-infected with the HIV virus. The more times you have unprotected sex with an infected partner, the more likely you are to be re-infected.

#### **Suggestions if you're positive:**

- **You may feel depressed, angry, or in shock– these feelings are normal.**
- **Talk to someone you trust.**
- **Join a support group of people living with HIV/AIDS.**
- **Take care of yourself**
- **Practice safer sex.**
- **Encourage your sexual partner(s) to also get tested.**
- **Do not ignore minor ailments**
- **Avoid drinking alcohol, smoking or taking drugs.**
- **Eat healthy foods and have a balanced diet.**

- **Exercise and rest adequately.**
- **If you are planning on having children, talk to you counsellor.**

#### **What are your rights?**

- You have the right to decide for yourself whether or not to have a test.
- Nobody has the right, not even a doctor, to do a test on you without your permission.
- The test result is private and confidential. This means that it is against the law for a health worker or counsellor to tell the test results to anyone without your permission.

**(ARV- GET TA FROM COSMAS)**

#### **PERSONAL RISK ASSESSMENT EXERCISE**

1. Do you now have a better understanding of HIV/AIDS and what it is?
2. Do you think AIDS is real?
3. Do you think you are at risk of becoming infected with HIV?
4. Do you think your past sexual life has put you at risk of becoming infected with HIV?
5. Do you have more than one sexual partner? What does this mean to you?
6. Do you know your HIV status or that of your sexual partner(s)?
7. Do you feel it is important to know it?  
If yes why?  
If no, why?
8. Do you know your HIV status?  
If no would you like to have an HIV test?  
If not, why?
9. How can you change your sexual behaviour to reduce your risk of becoming HIV positive and help others change too?  
How can you overcome the barriers to change?
- 10. How can you help those already affected with HIV/AIDS?**
11. Do you think using condoms can protect you from contracting HIV and STDs?
  1. Are you willingly to use a condom?
  2. Have you talked with your partner about using condoms? If not do you think you can talk with your partner(s) about using condoms in the future.
  3. **If you can't use condoms what measures are you going to take to protect your self from becoming HIV infected?**



# **CHAPTER 9: BASIC COUNSELING**

## **Facilitator Guide**

Introductory Paragraph.

### **Learning Objectives:**

By the end of the session, the peer educator will:

- Understand what counselling is and how it should be done
- Know what VCT is and its advantages
- Learn basic counselling skills

### **Duration:**

45 minutes

### **Materials:**

Flip charts.

### **Training methodology:**

Open discussion.

# CHAPTER 9: BASIC COUNSELLING

## Peer Educator Guide

Counselling is a process of dialogue or interaction between a skilled person/counsellor and person or group of people to deal with a crisis, enable a person to cope with stress, make a decision and/or solve a problem. The counselling process can be used when making personal decisions relating to HIV/AIDS and other health concerns. It includes the evaluation of personal risk of HIV transmission and the facilitation of preventive behaviour.

Voluntary counselling and testing (VCT) refers to a process through which individuals voluntarily seek counselling to prepare them for an HIV test. Counselling is an important part of VCT.

As a Peer Educator, one can give advice to peers in the workplace but referrals to trained counsellors is necessary. VCT services are available to all Zambians. VCT has many advantages:

- **Informed decision-making:** People who know their HIV status can make informed decisions about their sexual lives as well as whether or not to have children and how or if they want to breastfeed.
- **Improved health and medical treatment:** This allows for prompt effective treatment of all opportunistic infections as well as advice on nutrition and safer sex.
- **Psychosocial support:** It is important to receive well-planned and regular emotional, psychological and social support.
- **Prevention of HIV transmission:** People who seek VCT and know their status are able to protect themselves from further infection as well as protect others from new infections. Safer sex practices can be used to limit the possibility of further transmission.

### Basic Counselling Skills

The counselling process is one of dialogue and support for a person. There are three general stages to the counselling process that can be used to guide discussions.

#### 1. Helping the person to tell their story:

As a beginning stage, counsellors should help the person feel comfortable and encourage them to speak of their problem freely with an assurance that everything discussed will remain confidential. Some people may speak openly while also may need help. It is important to take time to establish trust with the person coming for help.

Asking open ended questions and displaying a positive and supportive attitude is essential.

#### 2. Help the person consider their options

Once a person understands their problem, a counsellor can help them in finding a solution. One must help the person determine various options for dealing with the problem at hand. A counsellor can ask questions relating to what the person may want and to imagine what things would be like if they were better. What would help the person feel better about the situation. This stage deals with exploring outcomes and getting results based on what the person's needs may be.

#### 3. Help the person make a plan

A person may know what they want to do and what they want to accomplish but may still need help in determining how to get there. A counsellor may ask questions such as, 'What do you think might be the best thing to do?'; 'What will you do now?'; 'How do you plan on doing it?'; 'Who do you think might be able to help you and when?'

Throughout all of these stages of counselling, it is important to practice the following behaviours: **caring, confidentiality, empathy, listening, and support**. As a counsellor, one must make the person being counselled feel comfortable by looking relaxed and comfortable, making and keeping good eye contact and being relaxed and open to anything the person may wish to discuss. Being non-judgemental is essential. A Peer Educator should refer people to trained counsellors for VCT as well as other issues as they arise. Counselling is a difficult process and should be carried out by a trained professional.

**Cultural Barriers to Effective Counselling:**

A good counsellor always listens and is prepared to discuss the client's beliefs and traditions. With assistance from a counsellor, a client can think through their cultural values and distinguish between those that are good and those that are potentially bad when it comes to the transmission of HIV/AIDS. For example, thinking about the tradition of cleansing may help the client to better understand why this can be a harmful traditional practice. When a husband dies of AIDS and his wife is then passed on to a brother or relative, it increases the chance that HIV will be spread to that brother or relative since there is a great likelihood that the wife is already infected.

Gender inequalities in Zambia can also play a role in the spread of HIV. In most Zambian homes, a woman has no right to refuse sex with her husband, even if she suspects that he has had unprotected sex outside the home. It is also difficult for a wife to ask her husband to go for HIV testing and counselling. Only a husband normally makes decisions of that nature. A woman that would like to be tested for HIV may also be told by her husband that she cannot go. The level of male dominance in such matters often contributes to the further spread of HIV. A woman, under these circumstances, cannot ask her husband/boyfriend to use a condom as she will be seen as promiscuous even if she may know that her husband/boyfriend has been unfaithful. This reality leaves Zambian women with few options for protection when they have no power to make such decisions.

Superstitions and faith in witch finders and herbalists can also contribute to the spread of HIV. When long illnesses or uncommon symptoms, such as those for an STD, are present, many people will choose to seek help from a traditional healer rather than modern medicine. While traditional healers may be well equipped to deal with many illnesses, HIV/AIDS and STDs are quite different. Issues around care seeking may also be discussed with a counsellor to overcome misconceptions about HIV and how it may be treated. It should also be noted again that, at present, there is no cure for HIV/AIDS.

Fear and apathy towards voluntary counselling and testing is also another barrier for many. There is a lot of stigma attached to HIV testing which makes it less attractive for most. Culturally, these barriers can keep people from going for testing since their peers and neighbours may discriminate against them and treat them poorly if they find out. People must be taught that HIV can strike anybody and that those found HIV positive must be supported.

## **CHAPTER 10: POSITIVE LIVING**

### **Facilitator Guide**

Once somebody has been tested and found HIV positive, there are many things they can do to lead a healthy and prolonged life. Topics covered in this chapter include: General Health; Opportunistic Infections; Nutrition; Alcohol & Drug Abuse; and Care and Support.

#### **Learning Objectives:**

By the end of the session, the peer educators will:

- Understand health issues in relation to HIV, including opportunistic infections.
- Know how to promote and maintain good health
- Understand how to identify community services and initiate collaboration with the community.

#### **Duration:**

30 minutes to cover issues

#### **Materials/Resources:**

Flip board

#### **Training methodology:**

Lecture

Open discussion

#### **1 minute role-play. Scenario as follows:**

A young man who is HIV positive looks much better health wise than another young man who is also HIV positive. The first man explains to the second that he is HIV positive but he ensures that any minor ailment is treated promptly to promote good health and prevent AIDS.

# CHAPTER 10: POSITIVE LIVING

## Peer Educator Guide

### General Health

It is important to seek prompt treatment for any illness to ward off the onset of AIDS. Psychological care includes how to accept one's HIV status and plan for the future, how to maintain self-confidence, and the importance of spiritual and psychological counselling. Good health practices include the following:

- Maintenance of personal and environmental hygiene
- A balanced diet and good nutrition
- Regular exercise
- Adequate rest
- Prompt treatment for ill health or minor ailments

### Opportunistic infections

Opportunistic infections and minor ailments are infections that take advantage of the damaged immune system and usually it is the infection that kills.

**Tuberculosis (TB)** - TB is the most common opportunistic infection associated with HIV. It is a communicable disease transmitted through coughing which usually affects the lungs. If you think you have TB, consult your local clinic for medicine. TB can be cured.

**Herpes Zoster** (shingles) has become a common opportunistic infection. It attacks the nerves and is very painful. It can appear at the trunk or face. Shingles are contagious, because the viruses are present in the fluid from the blisters.

**Kaposi's Sarcoma** is a cancer-like growth of the blood vessels. It appears as dark raised areas on the skin. These nodules can appear on the trunk, ears and nose and are itchy or painful. They spread into internal organs and eventually cause death.

**Meningitis** is caused by a fungal germ. Early symptoms include fever and mild headache followed by nausea, vomiting, headache and blurred vision. If untreated the disease is fatal.

**Oral thrush** is a white furry coat on the tongue and roof of the mouth and sometimes in the vagina.

**Enlarged lymph glands** are located in various parts of the body such as under the jaw, neck, armpits and groin. An early sign of AIDS is often painless bumps or swellings in these lymph nodes.

Other common infections are diarrhoea diseases, common cold, skin rashes, and abscesses. These opportunistic infections occur due to the weakened or damaged immune system and if treatment is not sought promptly an HIV infected person's condition may progress to AIDS quickly.

### Nutrition

Includes the importance of a balanced diet to stay healthy and maintain the immune system. Nutrients are essential to maintain a health body, and can be grouped as follows:

**Carbohydrates** include sugars, starches and fibres. Examples of carbohydrate foods are nshima, bread, rice, maize, sugar cane, cereals, honey, millet, wheat bread, yams, cassava and potatoes.

**Proteins** are body building foods. Examples of body building foods are meat, fish, eggs, milk, beans, groundnuts, skimmed milk, chicken, cheese, ifinkubala (caterpillar's) and kapenta.

**Protective foods** help the body to resist infections. The important vitamins and minerals are: vitamin A,C & D; iron, calcium, zinc

Traditional African foods that are available, cheap and provide a balanced diet are kapenta, pumpkin and bean leaves, groundnuts, soya beans, millet and sorghum, fish and plenty of tropical fruits.

**Community Support and Care Services**

Includes linking individuals to positive living clubs/home based care, sensitisation of the community on HIV to remove myths and misunderstanding about the spread of HIV/AIDS.

Peer educators should be knowledgeable about available HIV/AIDS support services in the communities of their catchment areas, and they should know how to access these services.

Communities may be able to offer some or all of the following:

- i) Home based care
- ii) Psychological support and counselling services
- iii) Support to carers and families of HIV infected persons
- iv) Positive living clubs
- v) Information centres
- vi) Peer education programmes
- vii) Promotion/provision of condom supplies
- viii) Other services provided by church groups, NGOs/CBOs

# **CHAPTER 11: GETTING STARTED**

## **Facilitators Guide**

This chapter provides some helpful hints for a Peer Educator to use in getting started with activities.

### **Learning Objectives:**

By the end of the session, the peer educator will:

- Display an understanding on the importance of planning effectively for HIV/AIDS activities at the workplace.
- Organize and manage a meeting
- Identify and select appropriate methods of presentation

### **Duration:**

45 minutes

### **Materials:**

Flip charts.

### **Training Methodology:**

Lecture / Discussion

Ask participants to simply brainstorm and list factors, which can lead to an unsuccessful AIDS activity programme. Ask them how those can be avoided to ensure a successful programme.

Work with participants in developing a sample implementation plan for the month to practice thinking about and planning for activities.

# CHAPTER 11: GETTING STARTED

## Peer Educator Guide

### Preparation:

- Peer Educators should conduct a needs assessment i.e. requirements needed to have the project/activity take place. Activities need to be planned in such a way that work production is not interfered. This can be effectively achieved by assessing the type of work, time of year, and activities at the workplace.
- Before calling a meeting, use the focal person/appropriate communication structures
- Peer Educators should plan their activities in advance to minimise disruption to company production, and to ensure that activities cover the four main thrusts of a workplace programme, i.e. i) information/facts on HIV; ii) condom promotion; iii) promotion of VCT; and iv) care and treatment for STIs. This involves assessing the nature of company business, work timetable, flexibility of working hours, time of year. In addition, the focal person should be fully aware of the peer educators work plan. To achieve maximum participation, sessions can be arranged during lunch / tea breaks/ after hours, or on weekends.
- For the programme to continue successfully, peer educators should observe punctuality and stick to the time allocated; reconfirm dates for presentation; know the subject area well, facilitate in a language acceptable and understood by the group; work with other peer educators to enhance the session and clearly articulate the message.
- Sessions are likely to be less well attended during paydays, funeral days, strikes etc.
- Peer Educators need to stimulate peoples' desire for the programme and hence the need to initially explain the purpose of the programme to workers so that it is accepted. To ensure coverage, Peer Educators need to meet different people/groups during sessions.
- For the programme to be ongoing, Peer Educators will need to make use of the following helpful hints when preparing for the group education session:
  - Know the session topic and observe objectives of the session
  - Reconfirm dates and venue for presentation
  - State what you want people to know and collect data on subject (research, consult etc.)
  - Select topic appropriate for the target group
  - List and write down important points you want to communicate
  - Identify who will carry out the various tasks e.g. counting of people etc.
  - Observe punctuality arrive preferably 15 minutes earlier and stick to the time allocated.
  - Facilitate in an energetic and lively manner
  - Prepare visual aids/models relevant to the topic
  - Arrange seating in such a way that the audience is able to see and hear clearly
  - Make the audience feel important by greeting them in a respectful, friendly way
  - Introduce yourself and the group
  - Commend the group for any positive information they contribute
  - Involve audience by utilizing their experience
  - Facilitate in a language that is acceptable and understood by the group
  - Invite the group to ask questions and answer them factually
  - Acknowledge the questions that you are not able to answer and inform the group that you will find the answer and let them know later
  - Involve other Peer Educators who are already trained
  - Help the audience understand why this information is relevant/important to them

### Methods of presentation

Most adults learn best by actively being involved in the learning process. Adults have a sense of personal dignity and so need to be treated with respect during sessions. They should never be humiliated. They learn

quickly about things that are relevant to their lives. They also have wide experience and have learnt much from life, it is therefore important to involve them when planning and during activities.

While AIDS education initiatives have successfully instilled high levels of knowledge about AIDS, this has not been matched by a high degree of behaviour change. Peer Educators therefore, need to choose different methods of presentation, according to the type of group in an effort to change knowledge, attitudes, behaviour/beliefs and practices.

Participatory approaches such as: Picture codes, role-plays, stories, songs, and drama are good discussion starters using guiding questions. Guiding questions include:

- What have we seen?
- Does this happen?
- What are some of the contributing factors to this problem?
- What are some of the consequences to this problem?
- How can we handle such a problem?

**Picture codes** are suitable for small groups; they result in energetic and spirited discussion when used properly. They work particularly well with mixed groups of men and women.

**Role-plays** are short plays acted by a few people. They are used to show a situation or problem and find ways of solving it. They are the cornerstones of behaviour change communication. Role-plays are useful in teaching communication and decision-making skills as well as attitudes.

**Songs** are used to relate AIDS messages and can be used as icebreakers or crowd pullers. They can be used to find the meaning of the songs and discuss whether what is described actually happens to the participants in real life.

**10 minutes dramas** can be performed for a large audience. They attract people and hold their interest because they are usually full of action and show what happens in real life hence stimulating lively discussion.

**Demonstration** can be used e.g. when discussing condom use and disposal. The Peer educator can divide participants into smaller groups ensuring that learners are involved as the method is showed step by step. The procedure must be visible to all.

**Participatory games** are an excellent way of ensuring audience attention and participation. Simple prizes may accompany games.

**Counselling** or one to one activities are appropriate for follow-ups in very small groups, and sensitive/personal issues that must be kept confidential.

## **CHAPTER 12: MONITORING & EVALUATION**

### **Facilitator Guide**

Two main topics are covered within this chapter. The first focuses on reporting to one's supervisor – how often, monthly meetings with focal persons and peer educators, and the use of diaries and notebooks. The second topic discusses collecting information – types of data (qualitative and quantitative), quarterly report monitoring.

#### **Learning Objectives:**

By the end of the session, the peer educator will:

- Understand what information is important to collect.
- Learn how to plan activities
- Importance of coordination

#### **Duration:**

45 minutes

#### **Materials:**

Flip charts.

#### **Training methodology:**

Open discussion.

#### **Exercise:**

Distribute the following Formats (ANNEX II) to participants and explain how to record:

- Monthly Activity Record – provides and tracks weekly activities
- Monthly Data Collection Form – elicits feedback on condom distribution, number referred for STI treatment and VCT
- Condom Stock Card – source of information for monitoring flow of condoms through the system
- Peer Educator's Diary – assists the peer educator in keeping his/her own individual records and to record promptly

## **CHAPTER 12: MONITORING & EVALUATION**

### **Peer Educator Guide**

#### **. Monitoring and Evaluation**

1. The collection of baseline data is essential before starting any workplace programme. A survey should be conducted with employees to gain an accurate picture of what their needs are. Questions should revolve around knowledge levels and understanding of HIV/AIDS and the like (Refer to annex II which shows a pre and post Peer Educators form) .
2. Reporting formats for peer educators should be simple and easy to collect and interpret results. There are three sample forms attached (see Annex II) which shows a) the monthly activity record; b) the monthly data collection form; c) the condom stock card. In addition, each peer educator keeps a small pocket size notebook and diary which provides more details on each session and lists appointments. Peer Educators are encouraged to initially organize 5 meetings per month in the workplace and increase gradually.
3. Peer Educators hold monthly meetings with the Coordinator or amongst themselves, depending on the structure in place. The forum is used to share experiences, events, problems, progress, causes of problems and potential solutions. Issues on the agenda includes: a) review of AIDS activities; submission of monthly reports, drawing up an action plan. The Leader collects the data, and compiles it into meaningful statistics.
4. Supervision and monitoring of Peer Educators is best achieved through regular meetings to take note of any new changes as well as recording and review to identify weaknesses/strengths and check performance. Ongoing training based on areas that need improvement may also be arranged.
5. The Supervisor or lead Peer Educator should compile a quarterly report for monitoring. Implementation of HIV/AIDS programme must be monitored to highlight progress of STI/VCT assessments, condom promotion/distribution and health talks and counselling sessions with peers.

#### **Meetings & Reports**

Record keeping is an important tool as it helps to gauge performance of peer educators and also assess progress of the programme. Peer Educators are encouraged to organize a few meetings per month and then increase the number gradually.

#### **Monthly meetings**

Peer Educators hold monthly meetings with the Coordinator. The forum is used to:

- Share experiences and learn from each other
- Update peers with AIDS information, events
- Highlight problems and seek ways to solve them
- Encourage people to be active and to work together
- Practice role-plays / presentations.

The agenda of items to discuss at the meeting may include:

- a) Collect reports as required **before** the meeting
- b) Appoint someone to take the notes or minutes
- c) Make announcements
- d) Review the last meeting notes and correct as needed
- e) State the purpose of this meeting and read the agenda items
- f) Ask if anyone wants to add agenda items
- g) Go through agenda items for discussion and or decisions as needed
- h) Share successes or accomplishments since the last meeting
- i) Raise problems, issues

- j) Discuss training needs or other needs
- k) Go over work schedules as needed
- l) Talk about the next meeting before closing
- m) Close on a positive note (sharing a story or experience observed among those in the group and recognize the others who performed well).

The Leader collects the data, and compiles it into meaningful statistics and submissions are made monthly to the Supervisor.

### **Supervision**

It is important for Supervisors to monitor their AIDS activities in the workplace to:

- Help motivate the peer educators
- Identify any performance gaps
- Review how the peer educators respond to difficulties encountered
- Assure the objectives and practices followed by the peer educators are in line with the project's objectives

### **Monitoring**

Peer educators are monitored through:

- Field support visits. The Project Coordinator plans and lists the companies to be visited, taking note of their schedule and arranges for a visit on appointment.
- Regular visits to take note of any new changes
- Record review to identify weaknesses/strengths, check performance
- Spot checks are done randomly without planning in order to follow-up and check activities. This helps Peer Educators to be alert and active. Ongoing training in the field based on areas that need improvement are also arranged.
- Quarterly reports: These reports are compiled by the Project Manager against 4 key tasks: mainly:
  - a) Implementation of HIV/AIDS Programme – this highlights progress of: STI/VCT assessments, condom promotion/distribution
  - b) Training Programme – in accordance with the performance guidelines
  - c) Supervision – monitoring visits to focal persons/peer educators
  - d) Monitoring and Evaluation – position data collection for the baseline survey.

## ANNEX I

### HIV Testing sites in Zambia:

<b>Southern Province</b>	<b>Telephone</b>
Livingstone General Hospital	032 324016
Maramba Health Clinic (Livingstone)	032 321677
Monze Mission Hospital	032 50593
Keemba Rural Health Centre (Monze)	032 50312
Choma (Kara Counselling)	
<b>Eastern Province</b>	
Chipata General Hospital	062 22731
Kapata Health Clinic (Chipata)	062 22266
Lundazi District Hospital	062 80076
<b>Central Province</b>	
Kabwe General Hospital	05 223049
Mahatma Gandhi Memorial Clinic (Kabwe)	05 223589
Serenje District Hospital	05 382066
<b>Lusaka Province-Lusaka</b>	
PPAZ Reproductive Health Centre	01 254728
Family Support Unit (UTH)	01 251200 Ext 2002
Chipata Healthy Clinic	01 292512
UNZA Clinic (Great East Road Campus)	
Hope House (Kara Counselling)	
Kamwala Clinic (Kara Counselling)	01 222453
Chawama Clinic (Kara Counselling)	
Mtendere Clinic (Kara Counselling)	
Matero Clinic (Kara Counselling)	01 245884
<b>Copperbelt Province</b>	
PPAZ Reproductive Health Centre—Kitwe	02 225114
Ndola Centre Hospital	02 612204
Lubuto Clinic (Ndola)	
Hope Humane (Ndola)	02 640668
Kamuchanga General Hospital (Muf)	02 410068
<b>Northwestern Province</b>	
Solwezi General Hospital	08 821534
Mwinilunga District Hospital	08 361024
Kabompo District Hospital	08 375023
<b>Luapula Province-Mansa</b>	
Mansa General Hospital	02 821188
St.Pauls Mission Hospital	02 972078
<b>Northern Province</b>	
Kasama General Hospital	04 221304

Mbala District Hospital	04 450058
Mpika District Hospital	04 450058
Chinsali District Hospital	04 565025
Tulumane Health Clinic (Mbala)	

**Western Province**

Mongu General Hospital	07 221011
Kaoma District Hospital	07 360107

**ANNEX II:**

**Monthly Activity Record**

Name of Company.....

Name of Peer Educator.....

Month/Year.....

Topic	Presentation Method	No of males Reached	No of Females Reached	Comments

Presentation Method: Role-play – RP    Video – VO    Group Discussion – GD    Slide Show – SS  
 Dance Troupe – DT    Demonstration – DN

**Monthly Data Collection Form**

Name of Company.....

Name of Peer Educator.....

Month/Year.....

Number provided with male condoms		Number supplied with female condoms		Number of Referrals		Reason for Referral	
Males	Females	Males	Females	Males	Females	Males	Females

**Condom Stock Card**

Name of Company.....

Year.....

Opening Balance.....

Month	Number Issued	BALANCE
Week 1		
Week 2		
Week3		
Week4		
	<b>Total</b>	<b>Total</b>

Annex 2

**PEER EDUCATOR DIARY**

Name of Company.....  
Name of Peer Educator.....

**KEY INFORMATION**

<b>Date</b>	
<b>Type: (Group / One to One)</b>	
<b>Place of meeting</b>	
<b>Time of Meeting</b>	
<b>Number of Peer Educators present</b>	
<b>Number of female participants present</b>	
<b>Method of presentation</b>	
<b>Topic(s)</b>	
<b>Number of people provided with condoms</b>	
<b>Number referred for STI</b>	
<b>Number referred for V.C.T.</b>	

**COMMENTS:**



## ACTIVITY RECORD

Name of Company.....

Name of Peer Educator.....

Month/Year.....

Topic	Presentation Method	No. of Males	No. of Females	Comments

**Presentation Method: Role-play – RP**  
**Slide Show – SS**

**Video – VO**  
**Dance Troupe – DT**

**Group Discussion – GD**  
**Demonstration – DN**

**MONTHLY DATA COLLECTION FORM**

Name of Company.....

Name of Peer Educator.....

Month/Year.....

Number provided with male condoms		Number supplied with female condoms		Number of Referrals		Reason for Referral	
Males	Females	Males	Females	Males	Females	Males	Females

**CONDOM STOCK CARD**

**Company Name**.....

**Month/Year**.....

**Opening Balance**.....

<b>WEEK</b>	<b>NUMBER ISSUED</b>	<b>BALANCE</b>
<b>Week 1</b>		
<b>Week 2</b>		
<b>Week 3</b>		
<b>Week 4</b>		
	<b>Total</b>	<b>Total</b>